UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
EVANSVILLE DIVISION

JONATHAN RICHARDSON a.k.a. AUTUMN CORDELLIONÈ,

Plaintiff,

v.

COMMISSIONER, INDIANA DEPARTMENT OF CORRECTION, in her official capacity,

Defendant.

Case No. 3:23-cv-135-RLY-CSW

DECLARATION OF MICHAEL FARJELLAH, PSY.D.

I, Michael Farjellah, Psy.D., being duly sworn upon oath and under penalties for perjury, declare as follows:

1. I am a psychologist licensed to practice in the State of Indiana.

2. From approximately April 2020 through September 2023, I worked as a clinical psychologist for the Indiana Department of Correction, treating prisoners throughout IDOC. Approximately twenty percent of my work for IDOC was conducted at Branchville Correctional Facility.

3. Prior to my work with IDOC, I was employed for 10 years as a clinical psychologist for the U.S. armed forces. My extensive military psychology background gave me a special appreciation for and attention to recognizing the end-of-life signs of a patient who has suicidal ideation.

4. I understand that the Plaintiff, Jonathan Richardson (#127630) a.k.a. Autumn Cordellioné, has filed a lawsuit against IDOC in which she seeks to obtain gender confirmation surgery.

5. In 2023, after she was transferred to Branchville Correctional Facility from Newcastle Correctional Facility, I interacted with Ms. Richardson on a couple of occasions. A true and accurate copy of my notes from these visits is attached to this declaration as Exhibits A through C.

6. My first interaction with Ms. Richardson occurred on May 8, 2023, when I saw Ms. Richardson for an individual psychotherapy session.

7. During the May 8 visit, I made the following notes in Ms. Richardson's chart:

> Interventions/Methods Provided:
> Pt recently transferred from NCF. She identifies as transgender. She has been incarcerated for murder in 2001 in which she admitted that "All I know is I killed the little f***ing b****" and the coroner stated that asphyxiation was the cause of death of her infant daughter. WRT her transgender status, she has been on hormone therapy for 4 years. Writer informed her that IDOC has decided to not go further with transgender surgery. She took the news well and said, "I'm used to disappointments. I used to self-harm and have attempted suicide, but I'm at peace now. I always knew I was a girl, but when I was younger I was a degenerate f*g. That doesn't define me now."
>
> Impressions: Pt has been through an extensive evaluation process and met with Transgender MDT in mid-2020 and was approved for surgery. She appears to be articulate, engaging, and forward looking, and has come to terms with her identity to a great extent. Not taking any psychotropic meds for many years. Likes to engage in psychotherapy to try and better herself.
>
> Plan: Maintain C code. Refer to psychiatry. F/u per policy.
>
> Current Assessment
>
> Assessment:
> Patient does not present any mental health issues at this time. Patient is responding to treatment plan. The patient is compliant with medications. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

(Ex. A at 2).

8. I also determined on the May 8 visit that Ms. Richardson had not expressed suicidal or homicidal ideation or intent, and that there was no need for a safety plan. (*Id.*).

9. I later updated Ms. Richardson's medical chart on May 21, 2023, to clarify that Ms. Richardson had not been recommended for gender confirmation surgery, but only hormone therapy. I made the following entry onto Ms. Richardson's medical chart on May 21:

> Interventions/Methods Provided:
> Correction from MH Intake note on 5/8/2023. Writer noted that Pt was approved for transgender surgery in 2020 by the GD MDT, but was approved for hormone therapy only for which she appears to be stable now for the past 3 years.
>
> Clarification: Pt was referred to writer by the MH staff upon arrival and she was inquiring about transgender surgery. We discussed the fact that IDOC leadership is currently undergoing some debate about the direction that transgender surgeries may go in the future and whether they are halted altogether or the process may resume. Richardson acknowledged understanding and did not seem distressed expressing "I'm used to disappointments. The surgery will eventually happen even if in not in here" (IDOC).
>
> Clinical Impressions: Pt has active diagnosis of borderline personality disorder. Given the gruesome history of murder, 20 years of incarceration, extensive history of suicidality (remote), numerous allegations/incidents of sexual abuse while incarcerated, extreme appearance, and active diagnosis of borderline personality disorder it appears she meets criteria for BPD. Writer does not recommend moving forward with surgery. Regional Leadership made aware of recommendation.
>
> Plan: F/u per policy. Maintain C code.

(Ex. B at 1).

10. As stated in my May 21 note, after having evaluated Ms. Richardson in my earlier therapy session, it was my professional opinion that Ms. Richardson was not a candidate for gender confirmation surgery and should not receive surgery. Among the reasons I did not recommend her for gender confirmation surgery was her active and appropriate diagnosis of borderline personality disorder, her remote history of suicide and/or self-harm attempts, numerous allegations of sexual abuse while incarcerated, and her extreme appearance.

11. Ms. Richardson had been diagnosed with borderline personality disorder for many years at the time I treated her. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) explains that the "essential feature of borderline personality disorder is a pervasive pattern of

instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts. Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, ca*n lead to profound changes in self-image, affect, cognition, and behavior.*" (*Borderline Personality Disorder*, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, p. 663) (emphasis added).

12. Ms. Richardson's borderline personality disorder influenced my opinion that she should not receive gender confirmation surgery. This is because it is impossible to disentangle the cause of Ms. Richardson's mental health symptoms. Her relatively recent identification as a transgender woman could simply be a manifestation of her borderline personality disorder.

13. Further, a borderline personality disorder diagnosis generally cannot be considered eliminated. It persists in various degrees of severity. An individual with this diagnosis can never be said to be stable because the nature of the diagnosis is that it can "erupt" at any time.

14. For these reasons, it was my professional opinion that Ms. Richardson was not a candidate for gender confirmation surgery.

15. Any administrative decision of the Indiana Department of Correction regarding gender confirmation surgery did not influence my opinion that Ms. Richardson was not an appropriate candidate for surgery.

16. On June 19, 2023, I met with MS. Richardson again for individual psychotherapy. I made the following note regarding the June 19 encounter:

> Interventions/Methods Provided:
> Pt describes that she met a 19-yo woman thru a friend in prison several years ago. She said that the young woman found a surrogate to get pregnant, but the I/I would be the father. However, she recently had a miscarriage and is currently in the hospital with suicidal thoughts, and apparently she came from an abusive environment too. This caused Ms. Richardson to cry uncontrollably which is spilling over into problems on the dorm. She requested to be allowed to not attend work for a few days which she

says she was allowed to do at other facilities. MHP Mr. Eli Sowry arranged this to happen through I/I's case manager.

Impressions: Complex case because the loss of this child may remind or haunt Pt of the loss of her own child whom she brutally murdered in the early 2000s. Tearful and appreciative in session.

Plan: Maintain C code. F/u per policy.

Current Assessment

Assessment:
Anxiety is significant. Cognitive issues are not significant. Substance abuse / dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania / manic behavior is not significant. The patient is compliant with medications. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

(Ex. C at 2).

17. I also determined on the June 19 visit that Ms. Richardson had not expressed suicidal or homicidal ideation or intent, and that there was no need for a safety plan. (*Id.*).

18. The June 19 interaction with Ms. Richardson stands out in my memory. Of note, I specifically that Ms. Richardson stated that she wanted to act as a surrogate *father* to the child of the friend mentioned in the note. I also recall Ms. Richardson reporting that she had never met the "19-yo woman" mentioned in the note in person.

19. Ms. Richardson was very emotional during the June 19 session. As noted, she was "crying uncontrollably" during the session. I believe the prospect of acting as a father figure to the woman's child provided Ms. Richardson with some hope, and that the situation was tied up with Ms. Richardson's past crime. More precisely, I believe Ms. Richardson during the June 19 session was re-living the loss of her own stepdaughter whom she was convicted of murdering, in an attempt to shift the level of guilt she experienced over the killing.

20. The extreme emotional outburst Ms. Richardson experienced on June 19, 2023, was symptomatic of her borderline personality disorder. Such extreme emotional reactions are typical of patients with a borderline personality disorder diagnosis.

21. During my two interactions with Ms. Richardson, I noted that she reported no suicidal ideations or intentions of self-harm. I also recall that Ms. Richardson seemed hopeful about the prospect of her future outside of prison, as her release was approaching. Therefore, at the time I treated Ms. Richardson, I did not see her as a suicide risk.

22. However, individuals with borderline personality disorder are statistically at higher risk for suicide attempts. This is another reason why it is difficult or impossible to disentangle gender dysphoria and borderline personality disorder as a possible cause of a patient's suicide or self-harm risk.

Verification

I declare under the penalties for perjury that the foregoing representations are true and accurate to the best of my knowledge, information, and belief.

Dated: FEB 26, 2024

Michael Farjellah

Michael D. Farjellah, PhD

State of Indiana
Department of Correction

Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: BTC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	05/08/2023 1:40 PM
VISIT TYPE:	Psychotherapy - Individual

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Individuals Present/Support Resources

Contact type:
Telemedicine
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Appearance: Other: extreme facial tattoos
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full
Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average

Exhibit A
STATE001132

Insight: Within normal limits
Judgment: Within normal limits

Goals, Objectives, and Interventions Addressed Today

Interventions/Methods Provided:
Pt recently transferred from NCF. She identifies as transgender. She has been incarcerated for murder in 2001 in which she admitted that "All I know is I killed the little fucking bitch" and the coroner stated that asphyxiation was the cause of death of her infant daughter. WRT her transgender status, she has been on hormone therapy for 4 years. Writer informed her that IDOC has decided to not go further with transgender surgery. She took the news well and said, "I'm used to disappointments. I used to self-harm and have attempted suicide, but I'm at peace now. I always knew I was a girl, but when I was younger I was a degenerate fag. That doesn't define me now."

Impressions: Pt has been through an extensive evaluation process and met with Transgender MDT in mid-2020 and was approved for surgery. She appears to be articulate, engaging, and forward looking, and has come to terms with her identity to a great extent. Not taking any psychotropic meds for many years. Likes to engage in psychotherapy to try and better herself.

Plan: Maintain C code. Refer to psychiatry. F/u per policy.

Current Assessment

Assessment:
Patient does not present any mental health issues at this time. Patient is responding to treatment plan. The patient is compliant with medications. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		05/08/2023	05/08/2023	No				
Property	Denies		05/08/2023	05/08/2023	No				
Homicide	Denies		05/08/2023	05/08/2023	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 72
Date: 05/08/2023.

Highest GAF: 72
Date: 05/08/2023.

SIGNATURES

Staff: Signed by Michael R. Farjellah, PsyD, on 05/08/2023

Behavioral Health Billing

Modifier: N/A

Document generated by: Michael R. Farjellah, PsyD 05/08/2023 02:00 PM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Exhibit A

STATE001134

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: BTC

PATIENT:	JONATHAN C RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	05/21/2023 9:16 AM
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Individuals Present/Support Resources

Individual not present.

Goals, Objectives, and Interventions Addressed Today

Interventions/Methods Provided:
Correction from MH Intake note on 5/8/2023. Writer noted that Pt was approved for transgender surgery in 2020 by the GD MDT, but was approved for hormone therapy only for which she appears to be stable now for the past 3 years.

Clarification: Pt was referred to writer by the MH staff upon arrival and she was inquiring about transgender surgery. We discussed the fact that IDOC leadership is currently undergoing some debate about the direction that transgender surgeries may go in the future and whether they are halted altogether or the process may resume. Richardson acknowledged understanding and did not seem distressed expressing "I'm used to disappointments. The surgery will eventually happen even if in not in here" (IDOC).

Clinical Impressions: Pt has active diagnosis of borderline personality disorder. Given the gruesome history of murder, 20 years of incarceration, extensive history of suicidality (remote), numerous allegations/incidents of sexual abuse while incarcerated, extreme appearance, and active diagnosis of borderline personality disorder it appears she meets criteria for BPD. Writer does not recommend moving forward with surgery. Regional Leadership made aware of recommendation.

Plan: F/u per policy. Maintain C code.

Risk Assessment

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Exhibit B
STATE001130

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 72
Date: 05/08/2023.

Highest GAF: 72
Date: 05/08/2023.

SIGNATURES

Staff: Signed by Michael R. Farjellah, PsyD, on 05/21/2023

Behavioral Health Billing

Modifier: N/A

Document generated by: Michael R. Farjellah, PsyD 05/21/2023 09:20 AM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

State of Indiana
Department of Correction

Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: BTC

PATIENT:	JONATHAN C RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	06/19/2023 11:10 PM
VISIT TYPE:	Psychotherapy - Individual

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 12:30 PM

End time: 00 hours, 30 minutes

Duration: 00 hours, 30 minutes

Individuals Present/Support Resources

Contact type:
Telemedicine
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Appearance: Other: multiple facial tattoos
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Mood: Depressed
Affect: Labile
Speech: Clear
Thought process: Logical
Perception: WNL

Exhibit C
STATE001096

Hallucination: Denied None evidenced
Thought content: Depressive
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Impaired ability to make reasonable decisions: Moderate

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Depressive symptoms do not impair daily functioning	Verbalizes increased feelings of self worth

Interventions/Methods Provided:
Pt describes that she met a 19-yo woman thru a friend in prison several years ago. She said that the young woman found a surrogate to get pregnant, but the I/I would be the father. However, she recently had a miscarriage and is currently in the hospital with suicidal thoughts, and apparently she came from an abusive environment too. This caused Ms. Richardson to cry uncontrollably which is spilling over into problems on the dorm. She requested to be allowed to not attend work for a few days which she says she was allowed to do at other facilities. MHP Mr. Eli Sowry arranged this to happen through I/I's case manager.

Impressions: Complex case because the loss of this child may remind or haunt Pt of the loss of her own child whom she britally murdered in the early 2000s. Tearful and appreciative in session.

Plan: Maintain C code. F/u per policy.

Current Assessment

Assessment:
Anxiety is significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. The patient is compliant with medications. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		06/19/2023	06/19/2023	No				
Property	Denies		06/19/2023	06/19/2023	No				
Homicide	Denies		06/19/2023	06/19/2023	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

Exhibit C
STATE001097

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 65
Date: 06/19/2023.

Highest GAF: 72
Date: 05/08/2023.

SIGNATURES

Staff: Signed by Michael R. Farjellah, PsyD, on 06/19/2023

Behavioral Health Billing

Start time: 12:30 PM
End time: 1:00 PM
Duration: 00 hours, 30 minutes
Modifier: N/A

Document generated by: Michael R. Farjellah, PsyD 06/19/2023 11:25 PM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

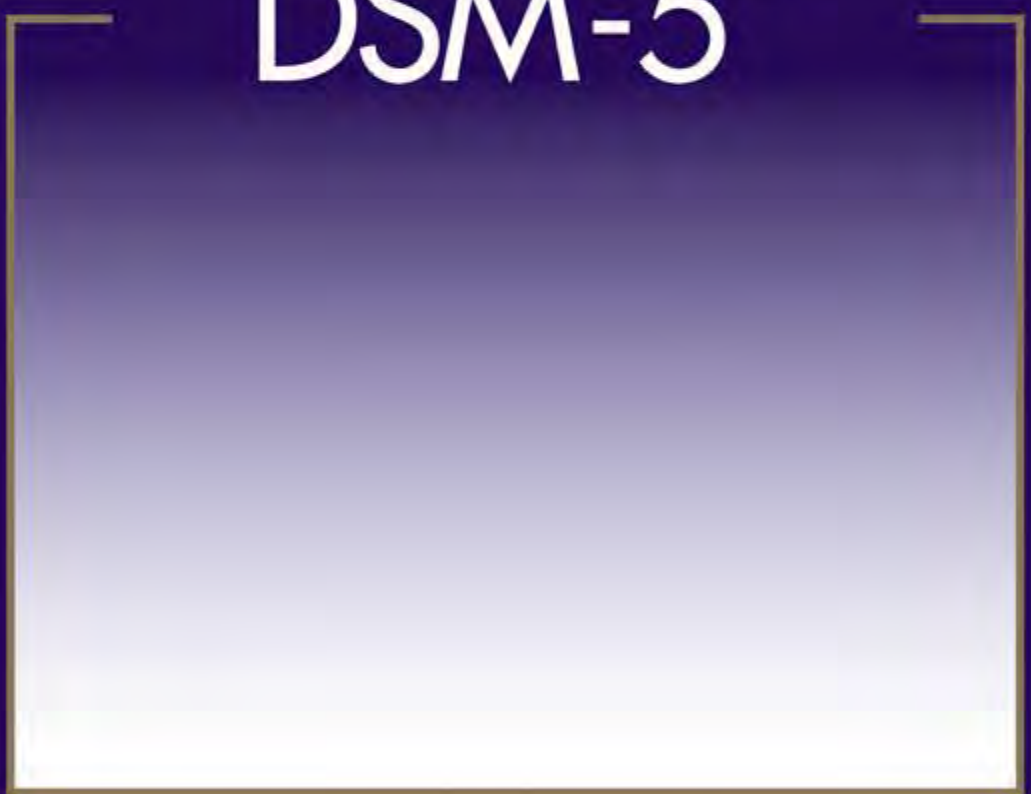
Exhibit C

STATE001098

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™



AMERICAN PSYCHIATRIC ASSOCIATION

manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification. Individuals with antisocial personality disorder tend to be less emotionally unstable and more aggressive than those with borderline personality disorder. Although antisocial behavior may be present in some individuals with paranoid personality disorder, it is not usually motivated by a desire for personal gain or to exploit others as in antisocial personality disorder, but rather is more often attributable to a desire for revenge.

Criminal behavior not associated with a personality disorder. Antisocial personality disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.

Borderline Personality Disorder

Diagnostic Criteria **301.83** (F60.3)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Diagnostic Features

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic

efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors, which are described separately in Criterion 5.

Individuals with borderline personality disorder have a pattern of unstable and intense relationships (Criterion 2). They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, or is not "there" enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will "be there" in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternatively be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). There are sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values, and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to that of a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support. These individuals may show worse performance in unstructured work or school situations.

Individuals with borderline personality disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly. Individuals with this disorder display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (Criterion 5). Completed suicide occurs in 8%–10% of such individuals, and self-mutilative acts (e.g., cutting or burning) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that the individual assumes increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil.

Individuals with borderline personality disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). The basic dysphoric mood of those with borderline personality disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to interpersonal stresses. Individuals with borderline personality disorder may be troubled by chronic feelings of emptiness (Criterion 7). Easily bored, they may constantly seek something to do. Individuals with this disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

Associated Features Supporting Diagnosis

Individuals with borderline personality disorder may have a pattern of undermining themselves at the moment a goal is about to be realized (e.g., dropping out of school just before graduation; regressing severely after a discussion of how well therapy is going; destroying a good relationship just when it is clear that the relationship could last). Some individuals develop psychotic-like symptoms (e.g., hallucinations, body-image distortions, ideas of reference, hypnagogic phenomena) during times of stress. Individuals with this disorder may feel more secure with transitional objects (i.e., a pet or inanimate possession) than in interpersonal relationships. Premature death from suicide may occur in individuals with this disorder, especially in those with co-occurring depressive disorders or substance use disorders. Physical handicaps may result from self-inflicted abuse behaviors or failed suicide attempts. Recurrent job losses, interrupted education, and separation or divorce are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss are more common in the childhood histories of those with borderline personality disorder. Common co-occurring disorders include depressive and bipolar disorders, substance use disorders, eating disorders (notably bulimia nervosa), posttraumatic stress disorder, and attention-deficit/hyperactivity disorder. Borderline personality disorder also frequently co-occurs with the other personality disorders.

Prevalence

The median population prevalence of borderline personality disorder is estimated to be 1.6% but may be as high as 5.9%. The prevalence of borderline personality disorder is about 6% in primary care settings, about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients. The prevalence of borderline personality disorder may decrease in older age groups.

Development and Course

There is considerable variability in the course of borderline personality disorder. The most common pattern is one of chronic instability in early adulthood, with episodes of serious affective and impulsive dyscontrol and high levels of use of health and mental health resources. The impairment from the disorder and the risk of suicide are greatest in the young-adult years and gradually wane with advancing age. Although the tendency toward intense emotions, impulsivity, and intensity in relationships is often lifelong, individuals who engage in therapeutic intervention often show improvement beginning sometime during the first year. During their 30s and 40s, the majority of individuals with this disorder attain greater stability in their relationships and vocational functioning. Follow-up studies of individuals identified through outpatient mental health clinics indicate that after about 10 years, as many as half of the individuals no longer have a pattern of behavior that meets full criteria for borderline personality disorder.

Risk and Prognostic Factors

Genetic and physiological. Borderline personality disorder is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for substance use disorders, antisocial personality disorder, and depressive or bipolar disorders.

Culture-Related Diagnostic Issues

The pattern of behavior seen in borderline personality disorder has been identified in many settings around the world. Adolescents and young adults with identity problems (especially when accompanied by substance use) may transiently display behaviors that misleadingly

give the impression of borderline personality disorder. Such situations are characterized by emotional instability, "existential" dilemmas, uncertainty, anxiety-provoking choices, conflicts about sexual orientation, and competing social pressures to decide on careers.

Gender-Related Diagnostic Issues

Borderline personality disorder is diagnosed predominantly (about 75%) in females.

Differential Diagnosis

Depressive and bipolar disorders. Borderline personality disorder often co-occurs with depressive or bipolar disorders, and when criteria for both are met, both may be diagnosed. Because the cross-sectional presentation of borderline personality disorder can be mimicked by an episode of depressive or bipolar disorder, the clinician should avoid giving an additional diagnosis of borderline personality disorder based only on cross-sectional presentation without having documented that the pattern of behavior had an early onset and a long-standing course.

Other personality disorders. Other personality disorders may be confused with borderline personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to borderline personality disorder, all can be diagnosed. Although histrionic personality disorder can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, borderline personality disorder is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness. Paranoid ideas or illusions may be present in both borderline personality disorder and schizotypal personality disorder, but these symptoms are more transient, interpersonally reactive, and responsive to external structuring in borderline personality disorder. Although paranoid personality disorder and narcissistic personality disorder may also be characterized by an angry reaction to minor stimuli, the relative stability of self-image, as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns, distinguishes these disorders from borderline personality disorder. Although antisocial personality disorder and borderline personality disorder are both characterized by manipulative behavior, individuals with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification, whereas the goal in borderline personality disorder is directed more toward gaining the concern of caretakers. Both dependent personality disorder and borderline personality disorder are characterized by fear of abandonment; however, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline personality disorder can further be distinguished from dependent personality disorder by the typical pattern of unstable and intense relationships.

Personality change due to another medical condition. Borderline personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. Borderline personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Identity problems. Borderline personality disorder should be distinguished from an identity problem, which is reserved for identity concerns related to a developmental phase (e.g., adolescence) and does not qualify as a mental disorder.